Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4880AGC	A. BUILDING _____ B. WING _____	02/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	1555 WEST HORIZON RIDGE PARKWAY HENDERSON, NV 89012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on February 27, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 105 total Residential Facility for Group beds with 40 beds for persons with Alzheimer's Disease and 65 beds for elderly and/or disabled persons, Category II residents. The census at the time of the survey was 37. Zero resident files were reviewed and six employee files were reviewed. One discharged file was reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Complaint #21041 was substantiated. (See Tag Y106). The following deficiency was identified:	Y 000		
Y 106 SS=D	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.	Y 106		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 106	Continued From page 1 This Regulation is not met as evidenced by: Based on record review and interview on 02/27/09, the facility failed to ensure that 1 of 6 employees was trained in first aid and cardiopulmonary resuscitation (Employee #6). Severity: 2 Scope: 1	Y 106		